DOVER SCHOOL DEPARTMENT
REQUEST FOR LEAVE OF ABSENCE

NAME: _____ DATE OF APPLICATION: _____

Type of leave requested (check each that applies):

[ ] Medical
[ ] Family
[ ] Military
[ ] Educational
[ ] Other _____

Start date (first day of leave): _____

Return date (date of return to work): _____

Reason for requested leave (explain why leave is necessary):

_____

_____

_____

_____

_____

_____

_____

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_____

_____

A certification from a physician or qualified health care provider is required for leaves due to the serious health of the employee, of the employee's spouse, child, or parent.

Employee's signature _____ Date: _____

I understand that if I do not return from my leave of absence at the expiration of this leave, unless an extension has been approved in advance, my employment may be terminated.

Superintendent's Signature: _____ Date: _____